FOR BHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030304

Facility Name: Four Fountains Convalescent Center

Address: 101 South Belt West (Number) Belleville (City) 62220 (Zip Code)

County: St. Clair

Telephone Number: 618-277-7700 **Fax #** 618-277-7363

HFS ID Number: 37-1182089001

Date of Initial License for Current Owners: 11/4/1985

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Brant **Telephone Number:** 618-277-7700

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven D. Brant

(Title) Executive Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) David C. Read, Consultant

(Firm Name & Address)

(Telephone) 618-234-2273 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	156	Skilled (SNF)	156	56,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,276	411	1,805	3,492	8
9	SNF/PED					9
10	ICF	29,318	13,662		42,980	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,594	14,073	1,805	46,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.62%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/04/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/4/1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 1,805

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	250,762	20,932	3,820	275,514		275,514		275,514			1
2	Food Purchase		185,973		185,973		185,973		185,973			2
3	Housekeeping	149,834	25,751	6,984	182,569		182,569		182,569			3
4	Laundry	63,095	12,866		75,961		75,961		75,961			4
5	Heat and Other Utilities							130,085	130,085			5
6	Maintenance	62,882	15,093	7,761	85,736		85,736	12,862	98,598			6
7	Other (specify):*											7
8	**TOTAL General Services**	526,573	260,615	18,565	805,753		805,753	142,947	948,700			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,860,882	128,216	378,068	2,367,166	(74,259)	2,292,907		2,292,907			10
10a	Therapy					74,259	74,259		74,259			10a
11	Activities	83,432	5,548		88,980		88,980		88,980			11
12	Social Services	85,118	67		85,185		85,185		85,185			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,029,432	133,831	385,268	2,548,531		2,548,531		2,548,531			16
	C. General Administration											
17	Administrative	153,540		108,000	261,540		261,540		261,540			17
18	Directors Fees											18
19	Professional Services			55,575	55,575		55,575	39,478	95,053			19
20	Dues, Fees, Subscriptions & Promotions			31,332	31,332		31,332	(7,135)	24,197			20
21	Clerical & General Office Expenses	152,307	11,371	44,904	208,582		208,582	7,114	215,696			21
22	Employee Benefits & Payroll Taxes			481,603	481,603		481,603		481,603			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,090	5,090		5,090		5,090			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							227,933	227,933			26
27	Other (specify):*			19,153	19,153		19,153	(1,529)	17,624			27
28	**TOTAL General Administration**	305,847	11,371	745,657	1,062,875		1,062,875	265,861	1,328,736			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,861,852	405,817	1,149,490	4,417,159		4,417,159	408,808	4,825,967			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Four Fountains Convalescent Center #0030304 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,051	15,051		15,051	244,654	259,705			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,827	24,827		24,827	414,241	439,068			32
33	Real Estate Taxes							95,294	95,294			33
34	Rent-Facility & Grounds			1,287,657	1,287,657		1,287,657	(1,287,657)				34
35	Rent-Equipment & Vehicles			7,928	7,928		7,928		7,928			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,335,463	1,335,463		1,335,463	(533,468)	801,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,967	4,222	54,189		54,189		54,189			39
40	Barber and Beauty Shops	25,711	1,510		27,221		27,221		27,221			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	25,711	51,477	89,632	166,820		166,820		166,820			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,887,563	457,294	2,574,585	5,919,442		5,919,442	(124,660)	5,794,782			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(279)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,360)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,419)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(111,721)		34
35	Other- Attach Schedule	(520)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (112,241)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (124,660)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Four Fountains Convalescent Center

ID# 0030304

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce	$ (520)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(520)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	130,085	0	0	0	0	0	0	0	0	0	130,085	5
6	Maintenance	0	12,862	0	0	0	0	0	0	0	0	0	12,862	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	142,947	0	0	0	0	0	0	0	0	0	142,947	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	39,478	0	0	0	0	0	0	0	0	0	39,478	19
20	Fees, Subscriptions & Promotions	(7,135)	0	0	0	0	0	0	0	0	0	0	(7,135)	20
21	Clerical & General Office Expenses	0	7,114	0	0	0	0	0	0	0	0	0	7,114	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	227,933	0	0	0	0	0	0	0	0	0	227,933	26
27	Other (specify):*	(1,529)	0	0	0	0	0	0	0	0	0	0	(1,529)	27
28	**TOTAL General Administration**	(8,664)	274,525	0	0	0	0	0	0	0	0	0	265,861	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,664)	417,472	0	0	0	0	0	0	0	0	0	408,808	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Four Fountains Convalescent Center** **#** **0030304** **Report Period Beginning:** **01/01/2005** **Ending:** **12/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	0	244,654	0	0	0	0	0	0	0	0	0	244,654	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,275)	418,516	0	0	0	0	0	0	0	0	0	414,241	32
33	Real Estate Taxes	0	95,294	0	0	0	0	0	0	0	0	0	95,294	33
34	Rent-Facility & Grounds	0	(1,287,657)	0	0	0	0	0	0	0	0	0	(1,287,657)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,275)	(529,193)	0	0	0	0	0	0	0	0	0	(533,468)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,939)	(111,721)	0	0	0	0	0	0	0	0	0	(124,660)	45

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				South Belt LLC	St. Louis	Real Estate
Four Fountains Associates	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	South Belt LLC	0.00%	$ 130,085	$ 130,085	1
2	V	6	Repairs and Maint		South Belt LLC	0.00%	12,862	12,862	2
3	V	19	Professional Fees		South Belt LLC	0.00%	39,478	39,478	3
4	V	21	Telephone		South Belt LLC	0.00%	7,114	7,114	4
5	V	26	Insurance		South Belt LLC	0.00%	227,933	227,933	5
6	V	30	Depreciation		South Belt LLC	0.00%	244,654	244,654	6
7	V	32	Interest		South Belt LLC	0.00%	418,516	418,516	7
8	V	33	Real Estate Taxes		South Belt LLC	0.00%	95,294	95,294	8
9	V	34	Rent	1,287,657	South Belt LLC	0.00%		(1,287,657)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,287,657			$ 1,175,936	$ * (111,721)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steven Brant	Executive Admin	Administrative	2.30	A	30	50.00	Salary	$ 60,181	17-1	1
2	Tim Crowley	Director/President	Administrative	0.00		8	20.00	Dir Fees	108,000	17-3	2
3											3
4											4
5											5
6			A- Columbia Conv Ctr		38,276						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 168,181		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	GMAC		X	Mortgage	$33,413.59	1/1/05	$ 5,758,000	$ 5,718,049	1/1/40	6.1500	$ 315,302	1
2	Union Planters		X	Mortgage	varies	3/1/04	5,100,000			variable	40,372	2
3	GMAC		X	Mortgage Ins							62,842	3
4												4
5												5
	Working Capital											
6	Southwest Bank		X	Credit Line	varies	2/1/02	500,000	418,691	5/1/06	var + 1.25	24,827	6
7												7
8												8
9	TOTAL Facility Related				$33,413.59		$ 11,358,000	$ 6,136,740			$ 443,343	9
	B. Non-Facility Related*											
10												10
11								Int Inc			(4,275)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,275)	14
15	TOTALS (line 9+line14)						$ 11,358,000	$ 6,136,740			$ 439,068	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 62,842 Line # 32

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Four Fountains Convalescent Center **#** 0030304 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 95,303	2
3. Under or (over) accrual (line 2 minus line 1).	$ 95,303	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 95,303	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	71,019	8
	2001	75,392	9
	2002	78,488	10
	2003	86,185	11
	2004	95,303	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Four Fountains Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0030304

CONTACT PERSON REGARDING THIS REPORT Steve Brant

TELEPHONE 618-277-7700 FAX #: 618-277-7363

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	$ 296.96	$ 296.96
2.	08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	$ 91.56	$ 91.56
3.	08-28.0-403-003	LOT/SEC-3 PT LYG S OF RICH CR	$ 45.46	$ 45.46
4.	08-28.0-403-004	LOT/SEC-4 PT LYG S OF RICH CR	$ 45.46	$ 45.46
5.	08-28.0-403-055	LOT/SEC 58 PT LTS 57 & 58	$ 87,521.56	$ 87,521.56
6.	08-28.0-403-056	LOT/SEC 58 PT LTS 57 & 58(2701)	$ 6,938.80	$ 6,938.80
7.	08-28.0-403-066	LOT/SEC 58 PT LT 58	$ 362.92	$ 362.92
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 95,302.72	$ 95,302.72

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,562 B. General Construction Type: Exterior brick Frame steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	218,250	1985	$ 585,985	1
2					2
3	TOTALS	218,250		$ 585,985	3

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		1985	1972	$ 3,826,500	$ 127,550	30	$ 127,550	$	$ 2,484,775	4
5	16		1996	1996	1,641,547	51,423	var	51,423		647,587	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1986	23,852	795	30	795		15,502	9
10	Land Improvements			1991	3,947		15				10
11	Building Improvements			1987	10,614	354	30	354		6,548	11
12	Building Improvements			1988	11,664	389	30	389		6,806	12
13	Building Improvements			1989	192,108	6,404	30	6,404		104,093	13
14	Parking Lot Repavement			1989	20,043		15			19,373	14
15	Building Improvements			1990	42,771	1,426	30	1,426		22,103	15
16	Building Improvements			1991	30,378	1,013	30	1,013		15,192	16
17	Land Improvements			1991	1,127	75	15	75		1,126	17
18	Building Improvements			1992	11,841	790	30	790		10,574	18
19	Carpeting			1992	318		7			315	19
20	Land Improvements			1992	3,777	252	15	252		3,386	20
21	Building Improvements			1993	1,253		7			1,251	21
22	Land Improvements			1993	2,581	173	15	173		2,197	22
23	Building Improvements			1993	12,614	841	15	841		10,587	23
24	Building Improvements			1994	6,876	459	15	459		5,470	24
25	Building Improvements & Land Improvements			1994	40,120		10			40,118	25
26	Building Improvements			1995	16,869	1,125	15	1,125		12,140	26
27	Building Improvements			1995	33,390	967	10	967		33,388	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Hot Water Pipes	1997	$ 1,303	$ 130	10	$ 130	$	$ 1,064	37
38	Storage Shed	1997	1,002	100	10	100		876	38
39	Laundry Water Tank	1997	2,050	205	10	205		1,845	39
40	Remodeling	1998	2,090	139	15	139		1,010	40
41	Replace Asphalt	1998	8,525	853	10	853		6,039	41
42	Therapy Kitchen	1999	7,500	500	15	500		3,458	42
43	Roof	1999	112,353	7,490	15	7,490		50,559	43
44	Shower	1999	1,910	127	15	127		859	44
45	Therapy Kitchen	1999	2,802	187	15	187		1,230	45
46	Water Heater	1999	9,806	654	15	654		4,249	46
47	Safe Stride Slip Resistant Floor	1999	480	32	15	32		195	47
48	Asphalt	2000	2,765	138	20	138		772	48
49	Sign Lettering	2000	900	45	20	45		248	49
50	Fire Suppression System, remodeling	2000	24,431	1,842	15	1,842		9,664	50
51									51
52	New lighting and fixtures	2001	6,360	424	15	424		1,943	52
53	New drains hall 100	2001	4,843	323	15	323		1,614	53
54	Day room remodel	2001	5,671	378	15	378		1,670	54
55	Dining room remodel hall 500	2001	12,079	805	15	805		3,557	55
56	Ansul system hookup	2001	1,900	127	10	127		633	56
57	Wallpaper, plaster,door	2002	8,146	543	15	543		1,865	57
58	Flooring	2003	480	32	5	32		96	58
59	Boiler and circuits	2003	4,900	327	10	327		915	59
60	Signage	2003	1,075	72	15	72		167	60
61	Storage	2003	2,835	284	15	284		782	61
62	Sprinklers	2004	1,108	74	15	74		129	62
63	Hall improvements/Metal door	2004	4,210	281	15	281		461	63
64	Asphalt	2004	4,155	208	20	208		260	64
65	Metal Doors	2005	1,048	64	15	64		64	65
66	Air conditioning	2005	20,057	891	15	891		891	66
67	Wall prep, patching, remodeling	2005	22,485	197	15	197		197	67
68	Windows	2005	67,837	377	15	377		377	68
69	Bathroom fixtures	2005	2,076	12	15	12		12	69
70	TOTAL (lines 4 thru 69)		$ 6,283,372	$ 211,897		$ 211,897	$	$ 3,540,232	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,283,372	$ 211,897		$ 211,897	$	$ 3,540,232	1
2	Fireproofing Insulation	2005	19,258	107	15	107		107	2
3	Electrical fixtures and wiring	2005	4,836	27	15	27		27	3
4	Roof Top Air Conditioner	2005	4,898	122	10	122		122	4
5	Sprinklers	2005	4,510	75	10	75		75	5
6	Sidewalks	2005	5,700	24	20	24		24	6
7	Fencing	2005	3,965	116	20	116		116	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,326,539	$ 212,368		$ 212,368	$	$ 3,540,703	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 557,784	$ 44,387	$ 44,387	$		$ 254,376	71
72	Current Year Purchases	38,524	2,950	2,950		5-10	2,950	72
73	Fully Depreciated Assets	1,128,959					1,128,959	73
74								74
75	TOTALS	$ 1,725,267	$ 47,337	$ 47,337	$		$ 1,386,285	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,637,791	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 259,705	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 259,705	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,926,988	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: South Belt LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	140	01/01/2005	$ 1,287,657	15	n/a	3
4	Additions	1996	16					4
5								5
6								6
7	TOTAL		156		$ 1,287,657 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1/1/05
Ending 1/1/20

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 7,928 Description: Office 6555, Dietary 1373
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$	1,116	$ 28,657	$ 87	1,116	$ 28,744	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		155	6,222		155	6,222	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,286	38,785	508	1,286	39,293	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				44,939		44,939	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray,Oxygen	39-2,3				4,222			4,222	13
14	TOTAL			$	2,557	$ 77,886	$ 45,534	2,557	$ 123,420	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Four Fountains Convalescent Center **#** 0030304 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,706	$ 58,706	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	1,058,243	1,058,243	3
4	Supply Inventory (priced at cost)	35,002	35,002	4
5	Short-Term Investments			5
6	Prepaid Insurance	9,966	695,886	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related	(165,205)	616	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 996,712	$ 1,848,453	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		590,140	13
14	Buildings, at Historical Cost		6,312,974	14
15	Leasehold Improvements, at Historical Cost		1,392,144	15
16	Equipment, at Historical Cost	342,531	342,531	16
17	Accumulated Depreciation (book methods)	(294,265)	(4,926,988)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): cap loan costs net		154,521	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 48,266	$ 3,865,322	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,044,978	$ 5,713,775	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,644	$ 371,291	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	418,691	418,691	29
30	Accrued Salaries Payable	133,704	133,704	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,215	4,215	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		29,305	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	accrued distrib	35,795	35,795	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 794,049	$ 993,001	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,718,049	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Mgmt Fees	439,588	439,588	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 439,588	$ 6,157,637	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,233,637	$ 7,150,638	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (188,659)	$ (1,436,863)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,044,978	$ 5,713,775	48

***(See instructions.)**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,057,619)	1	
2	Restatements (describe):		2	
3	**Audit adj**	(745)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,058,364)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(378,499)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (378,499)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,436,863)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,080,464	1
2	Discounts and Allowances for all Levels	(78,139)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,002,325	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	224,794	6
7	Oxygen	8,496	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 233,290	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	29,267	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,166	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,292	19
20	Radiology and X-Ray	6,213	20
21	Other Medical Services	51,009	21
22	Laundry	675	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 187,622	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,275	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,275	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Inc	1,712	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,712	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,429,224	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	948,700	31
32	Health Care	2,548,531	32
33	General Administration	1,337,400	33
	B. Capital Expense		
34	Ownership	806,270	34
	C. Ancillary Expense		
35	Special Cost Centers	81,410	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37	Rounding	2	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,807,723	40
41	**Income before Income Taxes (line 30 minus line 40)****	(378,499)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (378,499)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.**

return on extension

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,940	1,940	$ 59,096	$ 30.46	1
2	Assistant Director of Nursing	2,056	2,080	52,466	25.22	2
3	Registered Nurses	13,818	15,103	339,985	22.51	3
4	Licensed Practical Nurses	22,111	23,500	421,580	17.94	4
5	CNAs & Orderlies	80,580	84,668	950,118	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,959	4,151	37,638	9.07	8
9	Activity Director	7,946	8,492	83,432	9.82	9
10	Activity Assistants					10
11	Social Service Workers	3,864	4,160	85,118	20.46	11
12	Dietician	1,944	2,080	39,696	19.08	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,479	26,041	211,066	8.11	15
16	Dishwashers					16
17	Maintenance Workers	4,083	4,358	62,882	14.43	17
18	Housekeepers	20,458	21,965	149,834	6.82	18
19	Laundry	6,598	7,341	63,095	8.59	19
20	Administrator	1,944	2,080	93,359	44.88	20
21	Assistant Administrator					21
22	Other Administrative	1,054	1,088	60,181	55.31	22
23	Office Manager					23
24	Clerical	11,230	11,875	152,306	12.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,914	1,998	25,711	12.87	33
34	TOTAL (lines 1 - 33)	209,978	222,920	$ 2,887,563 *	$ 12.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	varies	7,200	9-3	36
37	Medical Records Consultant	12	480	10-3	37
38	Nurse Consultant	38	950	10-3	38
39	Pharmacist Consultant	varies	720	10-3	39
40	Physical Therapy Consultant	729	45,876	10-3	40
41	Occupational Therapy Consultant	158	14,772	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	48	4,800	10-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	985	$ 74,798		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,221	$ 109,410	10-3	50
51	Licensed Practical Nurses	6,795	119,612	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	11,016	$ 229,022		53

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Hope McNitt	Administrator	0	$ 93,359
Steven D Brant	Exec Admin	2.30	60,181
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 153,540

B. Administrative - Other

Description	Amount
Tim Crowley	$ 108,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 108,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 287
Foley	Legal	7,312
Greensfelder Hemker	Legal	2,437
Hinshaw Culbertson	Legal	1,859
Jennings Jacknewitz	Legal	239
Wessels and Pautsch	Legal	195
Schiff and Hardin	Legal	1,308
Union Planters	Legal	16,756
Van Ostrand	Legal	2,220
Jan Lee	Accounting	2,183
Rubin Brown & Gornstein	Accounting	17,950
Others	Accounting	2,829
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 55,575

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,469
Unemployment Compensation Insurance	37,906
FICA Taxes	212,163
Employee Health Insurance	133,709
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K	8,157
other misc benefits	1,199
TOTAL (agree to Schedule V, line 22, col.8)	$ 481,603

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,123
Advertising: Employee Recruitment	9,601
Health Care Worker Background Check	
(Indicate # of checks performed)	1,970
IHCA	7,176
Igenix publishing	396
AHCA publications	115
CTS antivirus	636
other misc	150
Group Purch	30
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,197

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,526
Seminar Expense	2,301
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,827

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8						N/A							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care 7176**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **43,795** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Rubin Brown & Gornstein** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.